AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name:_____ **Phone Number:** _____

Other Names Used: _____ **Date of Birth:** _____**Social Security Number:** XXX --_____ - _____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record (s) of the above-named patient.

PATIENT INFORMATION IS NEEDED FOR: PLEASE SELECT ONE OPTION

☐ Continuing Medical Care ☐ Military ☐ Personal Use ☐ School ☐ Insurance
☐ Legal Purposes ☐ Social Security/Disability ☐ Other: _____

DATE (s) OF TREATMENT: _____

INFORMATION TO BE RELEASED OR ACCESSED:

☐ Clinic Notes ☐ Consultation Report ☐ Immunizations ☐ All Records
☐ Procedure Notes ☐ EKG Reports ☐ Medication/Prescription List
☐ Lab/Pathology Reports ☐ Radiology Reports ☐ Problem List
☐ Behavioral Health ☐ Radiology Images ☐ Other _____

FORMAT REQUESTED FOR INFORMATION TO BE PROVIDED:

☐ Paper ☐ Electronic media, as available * ☐ Release to MyChart account, as available*
(* only applies to data stored electronically)

METHOD OF DELIVERY:

☐ Pick Up (You will be notified via a telephone call when records are ready for pick up)
☐ Mail to Address listed below
☐ Fax (Provide recipient information below)

_____ _____
Physician/Clinic name to release your records Address & Phone

May release the above information to:

Orthopedic Specialty Associates - Alliance
Dean Papaliodis, M.D Curtis Bush, M.D. George Lebus, M.D.
2401 Westport Parkway, Suite 150
Fort Worth, Texas 76177
Phone: 682-212-5480 Fax: 682-212-5480

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows: _____.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

_____
Printed Name of Patient or Legally Authorized Representative

_____ _____
For Department Use: MRN/Acct # Relationship to Patient